

THE MEDICAL SECURITY PROGRAM

Health Insurance Benefits for Unemployment Insurance Claimants

Application for Coverage

Your Medical Security Program (MSP) package contains an application, brochure and return envelope. Please read the enclosed brochure for eligibility requirements and health insurance benefits of Premium Assistance Plan versus Direct Coverage Plan.

Depending on your circumstances, you may apply for the Premium Assistance Plan or Direct Coverage Plan. The information requested on this form will be used to document your eligibility for the Medical Security Plan and enrollment in either the Premium Assistance Plan or Direct Coverage Plan.

Steps for completing the application:

1. **Read the brochure carefully before completing the application.**
2. Complete all 3 pages and every section of the form. Make sure all the information is correct. **Missing, incomplete and/or inaccurate information will delay the processing of your application and the date your coverage begins.**
3. **Return your completed application using the enclosed return envelope or mail to MSP Customer Service, PO Box 146758, Boston, MA 02114.**
4. If you have any questions about completing this form, or if you need interpreter's assistance, please call MSP Customer Service at 1-800-908-8801 (TTY/TDD at 1-800-522-1254) Monday through Friday from 8:30 a.m. to 4:30 p.m.

If you have any questions about completing this form, or you need it interpreted, call the Medical Security Program customer service unit at 1-800-908-8801 (TTY/TDD for the Deaf and Hard of Hearing 1-800-522-1254). Hours are Monday – Friday 8:30 a.m. to 4:30 p.m.

Если у Вас возникли вопросы в связи с заполнением этой формы или если Вам нужно перевести ее, звоните в отдел медицинского страхования (Medical Security Program или MSP) в отдел обслуживания клиентов по телефону 1-800-908-8801 (TTY/TDD для глухих или людей с ослабленным слухом 1-800-522-1254). Мы работаем с понедельника по пятницу с 8:30 утра до 4:30 дня.

Si tiene alguna duda al llenar este formulario o necesita su interpretación al español, llame a la unidad de servicio al cliente del Programa de Seguridad Médico (Medical Security Program) al 1-800-908-8801 (TTY/TDD para hipoacúsicos 1-800-522-1254) de lunes a viernes, de 8:30 a.m. a 4:30 p.m.

Se desidera ricevere ulteriori informazioni sul modo di completare questo modulo o se ha bisogno dei servizi di un interprete, si rivolga all'unità di servizio clienti del Programma di sicurezza sanitaria (Medical Security Program) all'1-800-908-8801 (TTY/TDD per i non udenti o le persone con problemi di udito 1-800-522-1254). L'orario è dal lunedì al venerdì dalle 8:30 del mattino alle 4:30 del pomeriggio.

Em caso de dúvidas sobre o preenchimento deste formulário, ou se necessitar de explicações adicionais em português, contactar o Serviço de Assistência do Programa de Seguro de Saúde (Medical Security Program) através do telefone 1-800-908-8801 (TTY/TDD para surdos ou pessoas com deficiências auditivas 1-800-522-1254). O horário é de segunda a sexta-feira, das 8:30 am às 4:30 pm.

បើអ្នកមានសំណួរស្តីពីការបំពេញក្រសួងសុខាភិបាល ឬត្រូវការ ឲ្យគេបកប្រែ សូមទូរស័ព្ទទៅផ្នែកបម្រើអតិថិជន នៃកម្មវិធីសុខាភិបាល សម្រាប់ពេទ្យ (Medical Security Program) តាមលេខ 1-800-908-8801 (TTY/TDD សម្រាប់អ្នកច្រើន ឬស្តាប់មិនសូវឮតាមលេខ 1-800-522-1254)។ ម៉ោងធ្វើការគឺពីថ្ងៃចន្ទ – សុក្រ ចាប់ពីម៉ោង 8:30 ព្រឹក ដល់ម៉ោង 4:30 ល្ងាច។

ຖ້າມີຂໍ້ສົງໄສໃດ ໆ ກ່ຽວກັບການຕື່ມເຈ້ງຟອມນີ້, ຫລືຕ້ອງການ ຄຳແປ, ໃຫ້ໂທຫາໜ່ວຍບໍລິການລູກຄ້າຂອງໂຄງການປະກັນ ສຸຂະພາບທີ່ 1-800-908-8801. (ລະບົບ TTY/TDD ຄຳຫລັບ ຄົນຫຼືໜ່ວຍຫລືຜູ້ທີ່ຟັງສຽງບໍ່ຖີບດີທີ່ 1-800-522-1254.) ເວລາ ເຮັດການຄືວັນຈັນຫາວັນສຸກ, 8:30 ໂມງເຊົ້າ ຫາ 4:30 ໂມງແລງ.

Si ou gen nenpôt kesyon sou kijan pou ranpli fòmilè sila, oubyen si ou bezwen yon moun entèprete li ba ou, rele depatman sèvis kliyan pou Pwogram sekirite medikal la nan 1-800-908-8801 (moun soud oubyen moun ki gen pwoblèm pou tande ka rele liy TTY/TDD a nan 1-800-522-1254). Lè ouvèti se lendi a vandredi ant 8:30 am a 4:30 p.m.

Nếu có bất cứ thắc mắc nào về việc điền hay cần thông dịch mẫu này, xin gọi đơn vị Dịch Vụ Khách Hàng của Chương Trình An Sinh Y Tế theo số 1-800-908-8801 (TTY/TDD cho người điếc hay bị lãng tai: 1-800-522-1254). Giờ làm việc: Thứ Hai đến thứ Sáu, từ 8:30 sáng đến 4:30 chiều.

如你對填寫這表格有任何問題, 或你需要把這表格翻譯. 請聯絡醫療安全計劃的客戶服務組 (Medical Security Program), 電話 1-800-908-8801 (失聰和聽覺有困難人士, 請致電TTY/TDD 1-800-522-1254). 辦公時間為星期一至五, 由上午8:30至下午4:30.

Please read the accompanying brochure before completing application. Please print clearly.

1. Applicant Information (the person receiving unemployment insurance benefits is the applicant):

☐ Ms.
☐ Mr. Last Name: _____ First Name: _____ M.I. _____
☐ Mrs.

Social Security Number: _____ - _____ - _____ Birth date: _____ / _____ / _____
Month Day Year

Mailing Address: _____

City: _____ State: MA Zip: _____

Telephone: _____

☐ Female ☐ Male ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Please indicate if you have ☐ Medicare ☐ MassHealth ☐ Commonwealth Care

2. Plan/Coverage Selection:

MSP has two plans: Premium Assistance and Direct Coverage. The MSP brochure explains the two plans and lists the eligibility requirements for each. Either plan is available for individual or family coverage.

a) Which plan are you applying for? (select one)

___ Premium Assistance – MSP reimburses a portion of your COBRA or self-pay premium (see brochure).

A copy of your COBRA letter from your employer indicating the name of your health plan, COBRA start date and the amount of your premium is required.

If you maintained your own health insurance, provide a copy of a bill indicating your monthly premium.

___ Direct Coverage – if you did not have prior insurance provided or the option to continue.

___ Direct Coverage with Hardship Waiver – for people who do not feel able to continue COBRA even with MSP subsidy.

For Hardship Waiver provide the following information:

- Continuing health care coverage notification (COBRA letter) from your former employer
- Detailed listing of monthly expenses

Without this information your request for a Hardship Waiver can not be processed.

If you meet the criteria for a Hardship Waiver you will be enrolled in the Direct Coverage Plan. If not, you will be enrolled in the Premium Assistance Plan. You will be informed of the decision in writing.

b) Which coverage are you applying for? (select one) ___ Family ___ Individual

c) Did you have insurance through your most recent employer? ___ Yes ___ No

If you answered no, proceed to question 3.

d) Do you have the option to continue the health benefit plan provided through your most recent employer?

___ Yes ___ No Date COBRA began _____

If you do not have the option to continue your employer health plan, reason _____

e) Are you responsible for 100% (all) of your monthly COBRA/self-pay premium? ___ Yes ___ No

f) Name of health plan _____ ___ Family ___ Individual

g) Monthly premium \$ _____

3. Family Information: Please provide the information requested about your current spouse and dependent children aged 18 or under, full-time students aged 23 or under, or disabled children regardless of age. Please submit proof of full-time student status or disability status with this application.
Fill out completely for each dependent.

	Full Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (Month/Day/Year)	Sex	Is this person a resident of MA?	Does this person have other health care coverage? If you answer yes, provide the name of the health plan
Spouse				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you are divorced or separated and must cover your spouse, include copy of divorce decree or separation agreement.

4. Applicant's Employer Information: Provide the information requested for *all* of your employers within the last six months. Include the following to verify your information:

Employer's Name	Employer's Address	Telephone Number

5. Spouse's Earned Income Information: Provide the information requested for all of your spouse's employers within the last six months. Include the following to verify your information:

- A copy of your spouse's last four pay stubs from each employer; or an original letter (no copies) verifying your spouse's wages signed by the employer from each employer.
- Please note if spouse is collecting unemployment insurance.
- If spouse has not worked in the last six months, a letter signed by spouse noting no employment.**
- If your spouse is self-employed, include Schedule C of Tax Return or a Profit and Loss statement.**

Employer's Name	Employer's Address	Telephone Number

6. "Other" than employer or unemployment income (Applicant and Spouse): Please provide information about any significant income (not reported above). "Other" Income may include, but is not limited to child support, severance, paid out sick time and vacation, SSI, rental income, worker's compensation, alimony, dividend and interest distributions, etc.

Source of Income:	Amount Earned in last 6 months	Estimated Earnings next 6 months

7. Important! Signature of Authorization and Certification: I authorize my health care providers, other health plans, and my former employer to release information from my records to the Division of Unemployment Assistance (DUA) and Blue Cross Blue Shield of Massachusetts (BCBSMA), acting as its agent, to:

- Inform the providers of health care service from whom I am seeking health care that I am eligible for this program.
- Release information from my medical records to, and request information from, third parties in order to verify information necessary to determine my eligibility for this program.
- Release information from my records to other governmental agencies as required by statute, regulation, and /or interagency agreement for the purposes of facilitating and reporting MSP services, benefits and costs, and ensuring the integrity of the Medical Security Program.

If I am applying for Direct Coverage, I ASSIGN to DUA the rights to payments for my health care services from any third party insurer to the extent that DUA has paid or is obligated to pay for those health care services for me and/or my dependents.

I hereby certify that I have reviewed all four pages of the application and that I have exercised my best efforts to obtain and truthfully report the information requested. I certify that all the statements made by me in this application are true and complete to the best of my knowledge and belief. I understand that DUA, will rely on the information provided by me in this application in determining my eligibility for MSP and associated benefits.

I understand that knowingly and willfully misrepresenting information provided on this form might subject me to criminal or civil liability under the laws of the Commonwealth of Massachusetts.

Applicant's Signature: _____ Date: ____/____/____

Printed Name: _____

If you are married and applying for a family membership, both you and your spouse must sign and date this application:

Spouse's Signature: _____ Date: ____/____/____

Printed Name: _____

**SEND IN AN ENVELOPE TO:
MEDICAL SECURITY PROGRAM
P.O. BOX 146758
BOSTON, MA 02114-0020**

For more information on the Medical Security Program, please visit: www.mass.gov/dua/msp



The Medical Security Program is administered by the Division of Unemployment Assistance,
an agency of the Department of Workforce Development